



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-05-5707-01
SURGICAL AND DIAGNOSTIC CENTER LP 729 BEDFORD EULESS ROAD WEST SUITE 100 HURST TX 76053	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
ATLANTIC MUTUAL INSURANCE CO Box #: 19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "We feel that the amount paid on a release of the first dorsal compartment and excision of ganglion cyst of the left wrist is not fair or reasonable. We feel that Atlantic Mutual should reimburse us more appropriately as \$85.43 does not cover our costs to perform this surgery." "We feel that Atlantic Mutual has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85% -100% of our billed charges. Please consider for additional payment."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - \$2,050.08

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary:

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/6/2004	M	ASC services for procedure code 82.21 and 83.01	\$2,050.08	\$0.00
Total Due:			\$0.00	

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on February 10, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on February 18, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - M-No MAR

2. The Division has determined that good cause exists to dismiss this request based on: the Requestor no longer operates an active practice at the above address. The Division was unable to contact the Requestor via telephone attempts; the listed phone number(s) have been disconnected. The health care provider has not provided a current, correct address or contact information in accordance with 28 Tx. Admin. Code section 102.4 (d) and/or 102.5.
3. For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is \$0.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.1, §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

_____	_____	<u>8/10/2010</u>
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.